tion. We have met many cases in which recurrent osteomyelitis was apparently due to the fact that the patient had infected tonsils, which had been overlooked, or infected roots of teeth or sinus infection, but most commonly the infection seemed to be located in the tonsils; sometimes these were small and buried, but contained abscesses which could not be demonstrated until the tonsils were removed. For a number of years we have made it a routine practice to remove the tonsils in all cases of acute or chronic osteomyelitis. Many of these cases suffer from chronic ferunculosis or chronic acne.

Among these cases who suffer from ferunculosis there are many who eat great quantities of sugar, which seems to predispose to the formation of superficial infection which in turn may supply the infectious material which is carried by the circulation into the bones causing osteomyelitis. These patients should give up the use of sugar in every form.

CONCLUSIONS

My experience, which covers a series of more than 200 histories, 151 of which I have analyzed, will justify the following conclusions:

1. In every patient suffering from pain in any bone, the latter should be carefully palpated at once.

2. Pain upon pressure over a bone indicates the presence of osteomyelitis or periostitis.

3. The earlier this is demonstrated the less destruction will occur if operated immediately.

4. The operation should consist in splitting the overlying tissues down to the bone through the periosteum.

5. The incision should extend beyond the painful area above and below.

6. The periosteum should be loosened to 1 or 2 cm. on each side of the incision.

7. As a rule, this should be the extent of the primary operation.

8. In rare cases of very circumscribed infection, the infectious area may be very carefully excised, care being taken not to spread the infection by rough handling of gauge, which should be very sharp.

9. Hot, moist dressings with electric light treatment hastens recovery.

10. The shaft of long bones should never be removed until involucrum has been formed.

11. The primary focus of infection should always be determined if possible.

12. As soon as the patient has recovered from the acute operation, the primary focus of infection should be removed if possible.

2106 Sedgwick Street.

Classified by the Newspapers—The following ad appeared in the classified section of some of the daily papers recently:

For Rent—Something New. Just what you have been looking for. Studio offices complete, with apt. conveniences. . . . They are suitable for chiropractor, musical, dramatic or academic instructor, osteopaths, hairdresser or similar professional lines.

A CASE OF SIMULATED PREGNANCY AND DELIVERY

By A. D. ELLSWORTH, Fresno

Cases are not rare in which a woman, for any one of a variety of motives or for none at all, deceives herself or attempts to deceive others in the belief that she is pregnant. It is much more unusual to meet with cases in which the pretense is made that delivery has taken place.

The motive in such cases is usually apparent, such as to obtain damages, to compel marriage, or to gain admission to a charitable institution and, as a rule, the claim is made that delivery was more or less remote, or at least not very recent. There seem to be no cases reported in which the affair has been staged in quite as elaborate a manner as in the present case, which is all the more surprising when we consider that the chief actress in the drama was an ignorant Mexican woman who had never had children.

A word of explanation as to her motive. It is almost unheard of for a Mexican woman of this type to seek or to produce an abortion; their desire is to have large families of children, who are to them a sort of insurance against want in old age. Women who have had as many as seven children will come to the doctor to find out what is the trouble that they do not have more. When a woman of this class is married, if she does not soon begin to produce this form of insurance, there is very apt to be trouble in the family.

In this case the young woman, after being married a few months, had evidently announced that she was pregnant. Later, when she found she was mistaken, she sought for some means by which she could find the "easiest way out."

The history given, which was, of course, partly fictitious, was as follows:

M. F., age 25, had never had any children. She had been married eleven months. Her last period had been in April or May (she was not sure which), which would make her at this time five or six months pregnant. She said that the day before she had been standing on a box reaching for something on a shelf, when she fell, striking the floor in a sitting position. This was at 4 o'clock in the afternoon, and nothing further had happened until 3 o'clock the next morning, at which time she said she had had a severe, prolonged pain and had passed a mass of tissue, which was shown me for examination.

In the poor light which was available, this might easily have been mistaken for an afterbirth. One feature, however, demanded inquiry, and that was how there could be so well developed an umbilical cord, but no foetus. She had not been to an old-fashioned toilet, and there seemed no other way of accounting for the absence of the foetus.

Although it is better, I believe, not to make any vaginal examination in such cases, at least in the midst of such unsanitary surroundings, yet here was a case in which it seemed to be imperative. Accordingly, a vaginal examination was made with a sterile glove. There was no softening or relaxation of the perineum, the cervix was hard and undilated, and the fundus was in the normal non-pregnant position.

The mass of tissue was taken away for further examination, and, in order that there might be no question, was sectioned and examined under the microscope.

Here is what this ignorant Mexican woman had done. She had taken a pig's liver, and on the undersurface of this she had punched a couple of holes. Through these she had passed a piece of pig's intestine, one end of which was then split; through the opening thus made she had passed the other end of the piece of intestine, and the loop thus formed had been drawn up tight, so that this "cord," which was about eight inches in length, appeared to come directly from the liver substance without any knot being apparent. Along with this work of art she had included a couple of collapsed lungs, evidently also from the pig, which served in the role of blood-clots.

As there seemed nothing to gain by undeceiving her family, they are still under the impression that a most unfortunate miscarriage has taken place.

Rowell Bldg.

A FEW NOTES ON HALLE'S CLINIC, WITH ESPECIAL REFERENCE TO HIS ENDONASAL SURGERY*

By ROBERT D. COHN, M. D., San Francisco

On my leaving Berlin this summer, after having spent a couple of months at Halle's clinic, it appeared to me a matter of regret that Halle's varied and important contributions to rhino-laryngology, especially operative, during the past ten to fifteen years had thus far not appeared in book-form and were accessible only in scattered journal articles and society reports, as well as to some extent in recent text-books. Halle stated that such a book is in preparation, but that owing to conditions in Germany its publication in the immediate future seemed far from assured. He had the kindness to place at my disposal his numerous reprints. These and my own observations and jottings are the basis of these notes.

Turbinectomy—Halle does no turbinectomies. Conchotomes and turbinectomy scissors are under the ban in his clinic. With its menace of subsequent rhinitis atrophica and pharyngitis sicca, he considers turbinectomy "unphysiological mutilation." He cuts off hypertrophied tips, but never sacrifies the structure proper. In operating in the upper and posterior parts of the nasal chamber he does not amputate the middle turbinate, but secures through its temporary subluxation the necessary space in which to operate.

Submucous Septum Resection—This is the most frequent of all the operations done. There is first of all the usual indication of impaired nasal respiration *per se*. In addition to that, Halle, as early as 1900 (Zur Behandlung des Empyems der Highmoreshoehle, Berl. Klin. Woch. 1900, No. 35), advanced the theory that normal nasal respiration is the main essential for the cure of acute and chronic empyemas, especially of the antrum and sphenoid, respiratory air being necessary for the mucous membranes not only of the nose itself, but likewise of the sinuses. He believes that the normal respiratory air current, both inspiratory and expiratory, by negative pressure draws the sinus fluids from the sinuses; that this air moreover is antiseptic and, acting by suction, tends to dry out the cavities. Hence, many empyemas, especially antral, are cured spontaneously as soon as normal nasal respiratory conditions are restored. As, furthermore, almost all intranasal operations performed require a maximum of operative space, a septum correction almost invariably precedes the various operative procedures described below.

The septum correction in adults is always done under local anesthesia and its technique except in one point is that practiced by American rhinologists. The incision is a slight modification of that of Killian. The cartilage is removed with a straight Ballenger swivel knife, is then pared down somewhat and thereupon reimplanted, the septum flap being sutured with Halle's own crook-shaped needle. Infection and septum abscess are not feared.

As to the operation in children, Halle believes that it should be done only exceptionally before the twelfth year. However, he has frequently operated upon children of 8 and some as young as 4. In the last-named cases the operation was under general anesthesia; in children from 8 upward he operates, as a rule, under local anesthesia.

Operation for Closing of Septum Perforation—This was first reported, with demonstration of cases, to the Berlin Laryngological Society in 1919 and published in the "Monatsschrift fuer Ohrenheilkunde" in 1921. Up to that time Halle had done the operation in 60 cases, with reported complete success in 56 and incomplete in 4. The operation is a modification of the Yankauer plastic and consists in the formation of two or three small flaps along the lower edge of the perforation, which are turned into it and partially close it. A large semi-circular flap is then outlined above the perforation and, after being displaced downward so as completely to cover the perforation and the smaller lower flaps, is carefully sutured in place. Tampons in the opposite side serve to press the smaller flaps against it until union ensues. The crescent-shaped defect resulting in the septum above heals promptly by epithelization. A good description of the operation is to be found in Passow and Claus's "Operationen am Gehoergang, an den Tonsillen und in der Nase," Leipzig, 1923.

The operation is easy in the reading and difficult in the performing. In the one case that I witnessed the operation was done on a man of 30 for a traumatic perforation, the result of an earlier septum correction. Although local anesthesia was perfect and the patient exceptionally tractable, the operation even in Halle's hands was difficult, tedious and troublesome.

Endonasal Frontal Sinus Operation—This is Halle's chef d'oeuvre, his main contribution to rhinological surgery. It is based upon the earlier operation of Fletcher Ingals, and was developed in the years just before 1910. Halle's technique is very briefly as follows: After the usual cocaine-novocaine anesthetization the middle turbinate is subluxated toward the septum. A large muco-periosteal flap corresponding to the entire region in

* Read before the San Francisco County Medical Society, November 27, 1923.